Attachment C.I.a.
to Family Care Waiver
Application Pre-Print

Section C:
Quality of Care and Services

Quality Assurance/Improvement
Standards and Guidelines

QA / QI Standards and Guidelines

Date: May 12, 1999
From: Monica Deignan, Center for Delivery Systems Development
To: Care Management Organization Demonstration Sites
Subject: Pre-Certification Phase (Phase2)
Quality Assurance/Quality Assessment Baseline Self-Assessment Survey

Attached is a baseline self-assessment survey that has been developed in order to help the CMO demonstration sites design their internal Quality Assurance/Quality Improvement (QA/QI) programs. The purpose of the survey is to educate CMO administrators and staff on the scope of the contract standards for the internal QA/QI program, to help Department staff determine how we can assist you in the implementation of the standards, and to provide a guide for you in developing your QA/QI workplan.

The QA/QI standards listed in the survey (**text in bold only)** were taken from the draft Health and Community Supports contract between the Department of Health and Family Services (the Department) and the pilot counties. Annually, during the demonstration project, CMOs will be asked to complete the self-assessment survey. Comparing the results of year-by-year surveys will help the CMO and the DHFS determine the success of the CMO demonstration project in implementing their QA/QI programs.

The QA/QI Standards

The standards included in this survey address only areas of CMO operations and performance that the Department has determined to be closely related to quality assurance and improvement. Obviously, there are other areas of operations the Department will consider in certifying CMOs, such as the provider network, marketing and enrollment, finances, claims processing, and fiscal solvency. The Health and Community Supports contract contains standards for each of these areas.

The QA/QI standards do not assume that the CMO has a fully operational internal QA/QI program. At this stage, the QA/QI standards should be read as contract requirements that the Department will ultimately expect every Care Management Organization contractor to meet. In order to make the standards realistic to newly forming CMO demonstration sites, it is expected that progressive implementation of the standards will occur over a three-year period.

The minimum standards that must be met at the time of Phase 3 contracting are:

- The CMO shows clear leadership support for implementing an effective quality assurance and improvement program. It demonstrates that this standard is met by having a clear organizational mission that emphasizes a consumer-oriented approach and improved outcomes.
- A management leader is designated whose function is to secure needed resources and support the program.
- An operational framework exists for implementing required QA/QI elements, which includes:
  - an initial coordinating structure;
  - a definition of the QA/QI purpose and structure within the organization;

- a delineation of the role of the CMO versus service providers versus members, attendants, and informal caregivers as they relate to QA/QI activities;
- organizational linkages with other CMO management activities, (e.g., grievances, provider services, resource allocation, etc.);
- adequate participation from a cross-section of providers and staff;
- identified opportunities for consumer involvement.

Major QA/QI components that the CMO should work on during the first contract year are:

- Develop the CMO infrastructure and operations necessary to spur continued improvement in quality over time;
- Engage the participation of providers in the design and implementation of quality improvement activities;
- Determine how you will oversee the quality of LTC services and supports provided by contracted providers;
  - develop processes to monitor, evaluate, and take actions necessary to improve care rendered by contracted providers;
- Develop systems for performance improvement projects:
  - Year 1 – understand processes that contribute to outcomes and collect baseline data;
  - Year 2 – implement improvement efforts;
  - Year 3 – re-measure indicators;
- Develop effective ways to capture consumer input.

Instructions for Completing the Survey

The CMO QA/QI baseline self-assessment survey is attached. Please complete the survey by circling the number in the right hand column that best indicates your CMO's status with regard to the corresponding QA/QI standard (**in bold type**). Feel free to comment or describe any of your survey responses in the margins or on the back of the pages. As this survey is also an opportunity to explore how best the Department can assist CMOs in meeting contract standards, please jot down any ideas you may have for technical assistance topics, tools, or training sessions and send them in with your completed survey.

As the baseline assessment is for educational purposes, there is no scoring mechanism, or any indication that some standards are more important than others are. Your CMO's responses to the survey will be confidential and will be used only by the CMO and the Department, to assess your progress throughout the CMO demonstration project.

If:	**Circle number:**
All components of the QA/QI standard are implemented	5
Most of the components of the QA/QI standard are implemented	4
Some of the components of the QA/QI standard are implemented	3
Few components of the QA/QI standard are implemented	2
No components of the QA/QI standard are implemented	0

The Guidelines

The guidelines that accompany the QA/QI standards are chiefly interpretive. That is, they expand on the standards, defining terms, providing a fuller explanation of what does and does not constitute acceptable ways of administering a given standard. Again, the aim is to provide the clearest possible guidance to CMOs, as your internal QA/QI program becomes operational. No guideline is supplied when a standard is self-explanatory.

Next Steps

Thank you for taking the time to complete the baseline self-assessment survey for your CMO. **Please return a copy of your completed survey to the Department by August 1, 1999.** Your CMO's survey responses will be reviewed with you after your survey has been reviewed and tabulated. If you have questions or concerns, please feel free to call Julie Horner at 608 261-8391 or e-mail her at horneja@DHFS.state.wi.us. Send survey responses to:

Julie Horner
DHFS, OSF, CDSD, Room 318
1 West Wilson Street
Madison, WI 53707-7850

Based on the completed survey responses, each CMO must develop a QA/QI implementation workplan that details a strategy and a timeline describing the CMO's plan for implementing all of the QA/QI contract standards. The workplan should detail specific activities to achieve compliance with contract standards. It must specify time frames and identify responsible parties for each activity. Please include a process for an annual evaluation of how the implementation plan is working and for making necessary changes. The CMO must also include an analysis of current resources and a plan for securing additional resources for future QA/QI functions and activities as needed. And finally, the workplan should identify how consumers will be involved in the CMO's QA/QI program.

The workplan is due 45 days prior to signing a Phase 3 Health and Community Supports contract with the Department.

cc: Angela Dombrowicki
RC/CMO Joint Implementation Team

CMO Quality Assurance/Quality Improvement
Baseline Assessment
May 12, 1999

Name of CMO:

Name of Contact Person: Phone:

Date Completed: E-Mail Address:

QA/QI Standard	CMO Assessment
A. QA/QI Plan, Program, and Coordination	
1. **The CMO's governing board or its designee has approved a written QA/QI work plan outlines the scope of activity and the goals, objectives, and timelines for the program. This QA/QI plan is submitted to the Department and approved before the effective date of the contract. The CMO's governing board or its designee sets new goals and objectives annually based on findings from QA/QI activities.** Guidelines[1]: The CMO has a written QA/QI workplan that includes a QA/QI program description and addresses QA/QI leadership and both quality assurance activities and quality improvement activities. The annual QA/QI workplan includes QA/QI objectives and a timetable for achieving the objectives. Each performance improvement project or other activity to be undertaken over a prescribed period of time to achieve the objectives, including how they will be accomplished, are described in the detailed QA/QI workplan. The QA/QI Program description builds on the CMO's mission and vision for the organization. It defines the scope and content of the program, as well as the roles and responsibilities of the individuals who are involved in the program. It describes the role, structure, and functions of the QA/QI committee (or other coordinating structure) and associated committees. The program's scope is broad, ranging from LTC service and support issues to health issues, and encompasses issues that are relevant to its enrolled population. The QA/QI workplan establishes deadlines for implementation of each QA/QI standard and includes procedures for monitoring to assure that deadlines are met, including ongoing monitoring of any contractors to whom any activity has been delegated. A single responsible individual or organizational component is identified for each activity, and there is accountability to the senior official with overall responsibility for the QA/QI program.	**5 4 3 2 0**

[1] These guidelines are acceptable ways of administering the QA/QI standards. Taking into account variations in a CMO's structure and operations, particular QA/QI standards may be implemented differently than the guideline specifies. No guideline is supplied when a standard is self-explanatory.

QA/QI Standard	CMO Assessment				
2. **The CMO implements a QA program to assure that the quality of care and services it provides either through CMO staff or sub-contracted providers is maintained at acceptable levels. The scope of activities to assure quality includes: potential problem identification through screening; verifying quality-related problems and causes; evaluation of problems to determine severity and whether or not further study is warranted by audit or other means; designing activities to address deficiencies; recommending corrective action plans; assuring the implementation of corrective actions plans; and conducting follow-up activities to determine whether or not care meets acceptable standards.** Guidelines: The CMO has written procedures for taking action whenever there are questions about care or services and when, through systematic monitoring mechanisms, quality issues are identified. Appropriate practitioners monitor and evaluate quality through review of individual cases as needed. Whenever care or services are determined to be inappropriate, substandard, or should have been furnished and were not, the CMO has a procedure for taking appropriate remedial action. The CMO has mechanisms to monitor and evaluate the effectiveness of corrective actions.	**5**	**4**	**3**	**2**	**0**
3. The CMO implements an effective QI program that aims at, through ongoing measurements and CMO interventions, demonstrable and sustained improvement in the selected quality indicator(s) related to member health, functioning and satisfaction.	**5**	**4**	**3**	**2**	**0**
4. The CMO has a written plan for evaluating the overall effectiveness of its QA/QI program to determine whether the program has demonstrated improvement, where needed, in the quality of service provided to its members. Guidelines: The QA/QI workplan explains how the program will be reviewed and evaluated so that necessary changes can be made. The evaluation plan assesses both progress in implementing the QA/QI program and whether the CMO has initiated and is actively conducting performance improvement projects. It considers whether activities in the organization's work plan are being completed on a timely basis or whether commitment of additional resources is necessary. The written evaluation includes recommendations for needed changes in program strategy or administration. These recommendations are forwarded to and considered by the governing body of the CMO. (Note: this standard does not require that an organization make major revisions in its QA/QI program each year. On the contrary, because time is needed to develop an effective program, repeated shifts in strategy would be evidence of lack of focus or adequate planning.)	**5**	**4**	**3**	**2**	**0**
5. The CMO's QA/QI program is administered through clear and appropriate administrative arrangements, such that:					
a. The governing board or a subgroup of board leaders is accountable for the QA/QI program;	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment				
Guidelines: QA/QI program leaders include at least the leaders of the governing body (or the governing body may designate appropriate leaders if the Board's involvement with QA/QI issues in not direct). The CMO QA/QI leaders are expected to set expectations, develop plans, and implement or oversee the implementation of procedures that assess and improve the quality of the CMO's governance, management, clinical and support functions and processes of care and services. The CMO governing body routinely receives written reports describing actions taken and progress made in meeting QA/QI objectives and improvements.					
b. A senior manager is designated as having direct authority to commit CMO resources to the QA/QI effort, and is responsible for QA/QI program implementation. Guidelines: There is a single member of the CMO management staff designated as the individual responsible for the overall functioning of the QA/QI program. This individual has the direct authority to commit organizational resources to the QA/QI effort.	**5**	**4**	**3**	**2**	**0**
c. The staffing level and available resources (and the commitment of additional resources over time) are sufficient to provide reasonable assurance that compliance with QA/QI standards are achieved within the maximum permissible time frame. (Three years) Guidelines: Resources include staff, data collection and analysis resources, space, and equipment. Resources may be shared with other organizational units.	**5**	**4**	**3**	**2**	**0**
d. A QA/QI committee or other coordinating structure (that includes both administrative personnel and providers) exists to clearly identify individuals or organizational components responsible for each aspect of the QA/QI program and ensure that effective organizational structures are in place to facilitate communication and coordination. Guidelines: The CMO has a multidisciplinary committee that includes both providers and administrative personnel who administer the QA/QI program. Other arrangements may be implemented, so long as the CMO can demonstrate that clearly identified individuals or organizational components are responsible for each aspect of QA/QI activity and that effective organizational structures are in place to assure communication and coordination. The QA/QI committee or other coordinating structure is effectively functioning. Meetings are held at appropriate intervals and adequately attended. There is evidence that issues raised are appropriately followed up in subsequent meetings or through other means, and that deliberations lead to actual directions to committee staff, other CMO personnel, and/or affiliated providers.	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment				
e. There is active participation in the QA/QI program by:					
• **Members or other individuals who meet the functional eligibility for the CMO's target population(s);** Guidelines: The CMO establishes some mechanism for obtaining member input on the priorities for its QA/QI program. Possibilities include member representation on a QA/QI committee or subcommittee or routine inclusion of QA/QI issues on the agenda for a general member advisory committee. To the extent feasible, input is obtained from members who are users of or concerned with specific focus areas; for example, priorities in the area of specific residential services are developed in consultation with users of these services and/or their families.	**5**	**4**	**3**	**2**	**0**
• **CMO staff and providers, including attendants and informal caregivers who are able to contribute to the QA/QI effort; and** Guidelines: CMO staff, providers and caregivers who are directly involved with providing care and services to members are involved in the development and implementation of specific quality improvement activities, including identifying, measuring, and improving aspects of care and service. CMO staff and caregivers may also serve as a conduit for information from members and providers and can help the CMO educate its subcontracted providers about the CMO's QA/QI program and specific activities and the results of these activities.	**5**	**4**	**3**	**2**	**0**
• **Long term care and health care providers with professional expertise appropriate to the services offered by the CMO.** Guidelines: All contracts with providers require participation in QA/QI activities, including provision of access to member records and cooperation with data collection activities. If subcontracted providers are not represented on the CMO's QA/QI committee or other coordinating structure, there is a provider subcommittee or other advisory group to assure that LTC and health care providers actively participate in key activities, including: developing indicators, analyzing project results, identifying and proposing solutions to problems, and aiding in communication of QA/QI activities and results to other providers.	**5**	**4**	**3**	**2**	**0**
f. There is collaboration among all aspects of the QA/QI activity and other functional areas of the CMO that impact the quality of service delivery and clinical care (e.g., utilization management, risk management, complaints and grievances, etc.). Guidelines: The CMO's QA/QI program description specifies the organizational and functional relationships of the CMO's business components and how they interact with the QA/QI program. The description includes how relevant information is forwarded to the appropriate leaders and the individuals responsible for coordinating the QA/QI program and performance improvement activities. Additionally, responsibility for carrying out recommendations generated through QA/QI activities are defined in writing.	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment
The CMO uses methods, such as interdepartmental teams, to improve processes across the organization. For example, the CMO might determine that one factor in poor outcomes for a given condition was an access problem: too few providers in a given specialty or in a given part of the service area. While the immediate intervention might be to recruit additional providers, the finding should also trigger a review of the CMO's policies and procedures for ongoing monitoring of network adequacy. In other instances, findings of QA/QI activities may trigger intensive review of the practice patterns of an individual provider, leading to interventions in the form of counseling, possible contract sanctions, or reporting to appropriate professional disciplinary bodies.	
6. The activities of the QA/QI program are documented. Guidelines: Timely written minutes and other extemporaneous notes record decisions and actions for internal and external use. Standards and the basis for standards are documented. Written policies and procedures exist for major functions and activities. Criteria for decision making are clearly documented. The bases on which projects, indicators and benchmarks are selected are well documented. The CMO is able to document that each of its QA/QI projects is based on complete and valid information, however this information is compiled.	**5 4 3 2 0**
7. The CMO remains accountable for all QA/QI functions, even if certain functions are delegated to other entities. If the CMO delegates any QA/QI activity there is: (Note: A CMO may, by written contract, delegate any activity required under the Health and Community Supports contract to another entity. However, as with any organization that enters into a Medicaid contract, the primary contracting organization remains entirely accountable to the State for performance of any delegated function. And, it is the sole responsibility of the CMO to ensure that the delegated function(s) is performed in accordance with applicable contractual requirements. This standard is not meant to imply that the organization is legally liable for the actions of its subcontractors, for example in cases of malpractice; any such liability is established by State or local law.)	
a. An evaluation of the prospective subcontractor's ability to perform the activities to be delegated; Guidelines: The CMO documents that it has approved the subcontractor's policies and procedures with respect to the delegated function, and verifies that the subcontractor has devoted sufficient resources and appropriately qualified staff to performing the function. (Note: Because of the wide variety of organizational structures and contractual arrangements, it is difficult to develop simple guidelines for the review of delegated activities. In any given situation, the review methodology adopted by the CMO should be that which is least burdensome for reviewers and for the CMO, yet which provides positive assurance that the activity in question is being performed in agreement with these standards.)	**5 4 3 2 0**

QA/QI Standard	CMO Assessment				
b. There is a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate; Guidelines: A mutually agreed upon document between the CMO and the delegate, which may be a contract, letter, or other document, clearly defines the performance expectations for the CMO. It identifies how the CMO will evaluate the delegate's performance. This mutually agreed upon document also specifies the remedies available to the CMO, including revocation of the delegation, if the delegate does not fulfill its obligations. The mutually agreed upon document also indicates what functions have been delegated and requires the subcontractor to comply with the requirements of the contract and of applicable law and regulations. When a function is only partially delegated, contract provisions clearly delineate which responsibilities have been delegated and which remain with the CMO. In the QA/QI area, for example, the CMO might develop topics for projects in consultation with an affiliated provider group but delegate the actual conduct of a specific project to the group. The CMO identifies instances in which a delegation has been made implicitly. For example, a contract with a provider group may hold the group responsible for providing or arranging for a wide range of services. The group may be expected to develop its own procedures for approving requests for referral services by its own practitioners. If so, the utilization management function has been delegated, and the CMO assures that the group complies with the standards for that function, including standards related to requests for expedited review of requests for services.	**5**	**4**	**3**	**2**	**0**
c. The CMO has a written procedure for monitoring and evaluating the subcontractor's performance on an ongoing basis and for conducting a formal review at least once a year; Guidelines: The CMO has appropriate structures and mechanisms to oversee delegated activities, which includes written procedures for monitoring and review of delegated activities. CMO staff who is qualified to assess the delegated function(s) conducts such monitoring. The annual evaluation is a comprehensive assessment of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote the CMO's overall goals and objectives for the delegated function.	**5**	**4**	**3**	**2**	**0**
d. The CMO has specified the when and how a corrective action plan will be implemented if subcontractor deficiencies or areas for improvement are identified. Guidelines: If any problems or deficiencies are identified in the annual review, the written evaluation specifies any necessary corrective action and includes procedures for assuring that the corrective action is implemented.	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment				
8. The CMO selects a Performance Improvement Project from one of the three specified focus areas and a consumer outcome within the selected focus area to monitor during the contract year using quality indicators and measures. (This activity must be initiated by end of the first contract year.) Guidelines: All CMO improvement projects involve measuring performance, implementing system interventions, evaluating the effectiveness of interventions, and planning for sustained or increased improvement. Project topics relate to aspects of care and services that are significant for the CMO's own population. After a topic has been selected, the CMO ensures that its measurement and improvement efforts are system-wide. Each project, to the extent feasible, reaches all members and providers in its network who are involved in the aspect of care or service under study. This does not mean that the CMO must review the performance of each and every provider who furnishes the services that are the subject of the project, or that it must survey every affected member. Sampling is acceptable so long as the CMO ensures that its samples are genuinely random.	**5**	**4**	**3**	**2**	**0**
a. Quality indicators are selected which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area; Guidelines: The quality indicators selected by the CMO measure outcomes such as changes in health status, functional status, and member satisfaction. In the absence of standardized quality indicators that measure outcomes, process measures are acceptable so long as the CMO can show that they are valid proxies, that is, there is strong evidence that the process being measured is meaningfully associated with outcomes.	**5**	**4**	**3**	**2**	**0**
b. **Appropriate individuals are identified to review processes of care and services involved in the project and collect baseline data so that areas requiring improvement are identified**; Guidelines: The CMO's assessment of its performance on the selected indicators is based on ongoing collection and analysis of valid and reliable data. Data for performance improvement projects are most commonly derived from administrative data generated by the CMO's information system or from review of member records. (In assessing some services, other sources such as member or provider surveys may be appropriate.) When data are derived from the CMO's information system, their reliability is obviously a function of the general reliability of the system. By contrast, when data are derived from direct review of member records or other primary source documents, steps are taken to ensure that the data are uniformly extracted and recorded. The CMO uses appropriately qualified personnel; this will vary with the nature of the data being collected and the degree of professional judgment required. The CMO has clear guidelines or protocols for obtaining and entering the data; especially if multiple reviewers are used or if multiple subcontractors collect data. Inter-reviewer reliability are assured through, for example, repeat reviews of a sample of records.	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment				
c. The CMO has a plan to improve care and services for the defined target population based on the interpretation of the findings identified from the analysis of the data. Guidelines: The CMO identifies opportunities for improvement and decides which opportunities to pursue. Improvement plans are implemented and include system interventions such as educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives to improve performance. Interventions that might have some short-term effect but are unlikely to induce permanent change (such as a one-time reminder letter to providers) are insufficient. (The CMO is not required to demonstrate conclusively, for example, through controlled studies, that a change in a controlled measure is the effect of its intervention; it is sufficient to show that an intervention occurred that might reasonably be expected to affect the results.) The expectation of system-level intervention does not mean that that interventions would not occur at a provider-specific or member-specific level. When issues with specific practitioners' performance need to be addressed, the QA/QI program works with individual practitioners/ providers to develop strategies to improve performance and subsequently measures to see if performance has improved. These activities however, do not meet the requirement for a performance improvement project.	**5**	**4**	**3**	**2**	**0**
d. A review and evaluation of whether or not the new interventions were effective in achieving the desired outcomes. Guidelines: Once baseline data are collected and the improvement plan implemented, the CMO continues to measure performance, either continuously or only until a specific level of performance is attained, to determine whether improvement is occurring. (Note that improvement in an indicator is not necessarily the same as improvement in the health or functional status of members. For example, a member's functional status may remain stable or actually decline over time. However, a CMO would demonstrate improvement on the indicator if it slowed the rate of decline, whether or not it actually improved the member's functional status.) The CMO conducts a repeat measurement after an interval of at least one-year following the first measurement reported after the improvement plan was implemented. The performance level observed in this repeat measurement exceeds the original baseline performance by an amount sufficient to show continued improvement.	**5**	**4**	**3**	**2**	**0**
B. Member Input					
1. The CMO has a means for providing members an opportunity to continually participate in CMO quality improvement and give input and feedback on the quality of the CMO services, such as: focus groups; consumer advisory councils; member participation on the governing board; the QA/QI committee or other committees; surveys of members who disenrolled; or task forces related to evaluating services.	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment				
Guidelines: The CMO has a plan for monitoring member satisfaction with its services to discover the areas of interaction with members that are working well and to identify opportunities for improvement.					
2. The CMO has a means for reaching out to diverse member populations, such as frail, homebound members, to provide opportunities for participation, input, or feedback. Guidelines: The CMO has processes to ensure adequate input from members with special needs and their families, providers, and advocacy groups. Such processes assure fair and adequate representation of members with special needs in activities that involve obtaining member input.	**5**	**4**	**3**	**2**	**0**
3. In addition to the ongoing member participation described above, the CMO has a plan for seeking formal member input, through member surveys, face-to-face interviews or other means, on the following: **a. The effectiveness of its communications with members;** **b. Access and availability for services in and outside of the LTC benefit package;** **c. Choice and continuity;** **d. Changes in functional and health status of members; and** **e. Other information of interest to consumers.** Guidelines: The CMO annually assesses complaints and appeals, requests to change care managers, and reasons for voluntary disenrollment.	**5**	**4**	**3**	**2**	**0**
4. The CMO has a plan for making the results of the annual member feedback on CMO performance available to the Department and members upon request. The purpose of this activity is to identify successes, potential problems and barriers to care and to provide potential members with information they need to choose a CMO. Guidelines: The CMO provides feedback on member satisfaction to members, practitioners and providers, as appropriate, to enable them to participate in quality improvement efforts.	**5**	**4**	**3**	**2**	**0**
5. The CMO has systems in place for acting on member feedback in a timely way, and a mechanism for reporting to the Department the results and any quality management projects planned in response to the results. (The annual member feedback activity can be used to obtain information for a Performance Improvement Project.) Guidelines: When the CMO identifies areas of member dissatisfaction, it follows a consistent process of improvement. The areas to be addressed are identified and prioritized, interventions are implemented, and re-evaluated to determine the extent to which satisfaction with those areas has improved.	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment
C. Provider Selection and Retention	
1. The CMO has a selection and retention process for individual practitioners that meets the requirements below. (The term "practitioner[2]" generally refers to any type of practitioner licensed to practice independently under state law, including physicians, non-physician practitioners furnishing either health care or mental health and substance abuse treatment, and other health professionals.)	
a. Initial selection is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.	**5 4 3 2 0**
b. Reassessment of individual practitioners shall be accomplished: • **Every two years; and** • **Through a process that updates information obtained during the initial selection process and considers performance indicators, including those obtained through the following:** – **The QA/QI program;** – **The utilization management system;** – **The complaint and grievance system;** – **Member satisfaction surveys; and** – **Other CMO activities.**	**5 4 3 2 0**
Guidelines: The CMO has written policies and procedures for the selection and retention of practitioners, which are approved by the governing body. These policies include items such as criteria for the initial assessment and reassessment, at specified intervals, of qualifications and other relevant information pertaining to a practitioner who seeks employment from or a contract with a CMO. The criteria are appropriate to the nature of the services to be furnished to members. The selection process is integrated with the process of establishing and maintaining an adequate network. The reassessment process ensures that practitioners maintain current knowledge, ability, and expertise in the specialty in which they practice as appropriate. The process also takes into consideration data including, but not limited to: member complaints and grievances, results of quality reviews, utilization management information, disenrollment data, and member surveys. <u>Application</u> The practitioner completes an application for inclusion in the CMO network. The application includes a work history and a statement by the applicant regarding any limitations in ability to perform the functions of the position, with or without accommodation; history of loss of license and/or felony convictions; and history of loss or limitation of privileges or disciplinary activity.	

[2]For example, ``practitioner'' means any of the following: a psychologist, physician, physician assistant, physical or occupational therapist or therapist assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed or certified social worker, registered respiratory therapist and certified respiratory therapy technician.

QA/QI Standard	CMO Assessment
Verification of information The CMO verifies from primary sources (if applicable) the following information and includes it in practitioner records: 1. a current valid license to practice. In addition, the CMO obtains and includes in its practitioner records: 1. information on current, adequate malpractice insurance meeting the CMO's requirements; 2. information on professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner; 3. information about sanctions or limitations on licensure from the applicable state licensing agency or board, or from other groups; 4. information on previous sanction activity by Medicare and Medicaid. (This may be obtained through the HHS Medicare and Medicaid Sanctions and Reinstatement Report or through direct contact with the Medicaid agency or the Medicare intermediary.) Site visit The CMO's procedures may provide for a site visit to the office of certain specified practitioners such as high-volume licensed practitioners, e.g., psychologists or physical therapist. The procedure specifies the criteria for determining whether or not a practitioner is "high-volume." Clinical personnel (or teams including clinical personnel) conduct site visits. They should include an evaluation of the site's accessibility, appearance, and space, and of the adequacy of equipment, using standards developed by the organization. In addition the visits should determine whether the site conforms to the CMO's standards for member record keeping practices and confidentiality requirements.	
2. **Other providers. For providers who do not meet the definition of individual practitioner (this includes individual providers such as personal care workers and home health aides, and agency providers such as nursing facilities and home health agencies), the initial selection process and reassessment at specified intervals shall be accomplished to ensure that, at a minimum, the provider is licensed (if the Department requires licensing to operate in the State) and is in compliance with any other Federal or State requirements.** Guidelines: Similar processes as those described above are used for the selection and retention of providers who do not meet the definition of individual practitioner. (Note: The significant difference between the selection and retention process for providers in this section vs. individual practitioners are that primary source verification of licensure is not required. That is, the CMO may rely solely on documentation supplied by the provider. Current documentation should be at periodic intervals, and contracts should provide for notice from the provider of any change in its licensure or accreditation status.)	**5 4 3 2 0**

QA/QI Standard	CMO Assessment
3. The CMO's use of formal selection and retention criteria shall not discriminate against particular practitioners or other providers, such as those who serve high risk populations, or specialize in conditions that require costly treatment. Guidelines: Peers, through establishment of a provider/practitioner selection and retention committee or other mechanism, review the CMO's selection and retention criteria. The CMO may rely on determinations by Medicare or Medicaid in their assessment of providers/practitioners and, in addition, may develop its own approval criteria and determine that the providers/practitioners meet those standards before including them in its network. The CMO also has a process for peer review when the CMO is considering employing or contracting with a provider or practitioner who does not meet its established standards.	**5 4 3 2 0**
D. Authorization of Services and Utilization Management	
1. The CMO shall have documented policies and procedures for determining approval or denial of services. These policies require review and approval by the Department before the initial contract is signed. These policies shall be stated in the Member Handbook. (Note: The standards and processes in this section apply to a CMO's initial (i.e., pre-service) decision or determination in response to a request by a member (or by a provider on behalf of the member) for coverage of a service or continuation of a service previously approved. They also apply when an individual practitioner affiliated with a subcontractor of the CMO must seek approval of services within the subcontractor's own internal review system. However, they do not apply when a member requests a service directly from a practitioner and the practitioner is authorized by the CMO to decide whether or not to furnish or arrange the service without referring the request to anyone else, such as a case manager.) Guidelines: The CMO has procedures for obtaining services, including authorization and referral requirements, which include clear explanations of covered services, including any general coverage decisions with respect to specific procedures or services. The procedures include the procedures for obtaining mental health and substance abuse services, as well as the procedure for obtaining out-of-area coverage. The CMO follows these written policies and procedures for processing requests for services in a manner that ensures access to services. Utilization management activities are not structured in a manner that is detrimental to members. The CMO identifies, defines, and specifies all benefits that the CMO furnishes for members. The CMO ensures that there is no ambiguity concerning the range of covered services that are available to members in the benefit package vs. services that are available under other arrangements, e.g., Medicaid fee-for-service program. In all cases, utilization management procedures make it clear that a member has immediate access to emergency services at the nearest provider when and where the need arises without advance authorization.	**5 4 3 2 0**

QA/QI Standard	CMO Assessment				
a. Policies must take into account anticipated long term social and quality of life issues. Such consideration includes implications for independent living, support for the least restrictive residential setting for the member, and skill acquisition for the member to perform activities of daily living. Guidelines: CMO policies address both the routine and unique health and social needs of members. The CMO adapts its authorization procedures appropriately for members who prefer the self-directed support options.	**5**	**4**	**3**	**2**	**0**
b. The CMO shall specify information required for advance authorization decisions, have mechanisms to ensure consistent application of review criteria for advance authorization decisions, and consult with the requesting provider when appropriate. Guidelines: The CMO ensures that all employed or contracted reviewers understand coverage policies and review criteria, through manuals, training programs, or other means. In addition, the CMO periodically assesses the consistency of authorization decisions. Possible approaches may include review of test cases by different utilization management staff or audits of samples of recent decisions. In addition, upon request, the CMO should furnish members (or their representatives) and requesting provider(s) the review criteria that is used to reach a decision.	**5**	**4**	**3**	**2**	**0**
c. Policies shall specify time frames for responding to requests for initial and continued determinations as expeditiously as the member's situation requires. Guidelines: At a minimum, CMO policies specify the timeframe for responding to requests for initial and continued authorization, provide for expedited response to requests for authorization of services needed in an urgent manner, specify the information that is ordinarily required to process and authorize the request, and provide for consultation with requesting providers when appropriate. The CMO information standards ensure that the authorization process is not unduly burdensome for practitioners, provider staff, or members. Timeframes may differ according to the urgency of the need for the requested services and the complexity involved in evaluating the request; however, the CMO is be able to demonstrate that its timeframes are reasonable. Information is not required that is not in fact used in the evaluation or recording of the request.	**5**	**4**	**3**	**2**	**0**
d. Qualified professionals must be involved in any decision-making that requires professional or discipline-specific judgment. Guidelines: In processing requests for initial or continuing authorization of services, the CMO and its subcontractors follow written policies and procedures that reflect current standards of care and utilize the services of appropriately trained health care personnel to make these decisions. For most services, a qualified professional is an appropriate	**5**	**4**	**3**	**2**	**0**

QA/QI Standard	CMO Assessment
licensed practitioner (e.g., for substance abuse services, an addiction specialist; in the case of requests for mental health services, a licensed mental health professional.) The CMO has a policy that no denial of authorization on grounds of clinical appropriateness may be issued before the appropriate qualified professional has reviewed the request. Other personnel may approve requests, and may collect information for use by the qualified professional in evaluating a request. However they issue denials only on grounds clearly unrelated to clinical considerations—for example, because the member is no longer enrolled, or because the requested service is explicitly excluded from the member's covered benefits. (Benefit determinations involving professional judgment, such as a determination that a given procedure was experimental, would require review by the qualified professional.)	
e. All requests for advance authorization of services by a member or a provider shall be recorded, along with the disposition. The CMO compiles aggregate data for use in its own quality assessment and monitoring and which are available to the Department upon request. Guidelines: The CMO collects at least the following information on all requests: requesting practitioner/provider, member, date of the request, service(s) requested, initial response (authorization, including quantity or duration of services authorized, or denial), and date of initial response. In the case of denials that result in a request for appeal, the CMO also records the reason for the denial, information used in reconsidering the request, and the ultimate resolution of the request. The CMO provides the requesting provider and the member written notice of any decisions to deny, limit, or discontinue authorization of services. Appropriate information regarding rights to file a grievance or request a State fair hearing is also included with this notice. Further, information is included regarding how continuing care can be received during an appeal process. In setting the timeframe for providing this notification, the CMO ensures that the timeframe does not jeopardize a member's health. The manner in which this notice is provided ensures that the CMO can document when the requesting provider receives the information and whether members are able to comprehend what is stated.	**5 4 3 2 0**
f. The CMO shall communicate to providers, upon request, criteria used for review and approval of specific services. Guidelines: A CMO may develop its own criteria for review of authorization requests or adopt criteria developed by outside resources. In either case, the CMO's procedures provide that affiliated practitioners review criteria before their adoption, and that mechanisms for periodic re-evaluation of the criteria exist. If the CMO has developed standard criteria for approval of a specific procedure or service, these criteria are be made available on request to any member or affiliated provider.	**5 4 3 2 0**

QA/QI Standard	CMO Assessment				
The CMO notifies affiliated practitioners and providers of the information ordinarily required for processing an authorization request, and of the circumstances under which additional information may be required. The CMO's information standards assure that the authorization process is not unduly burdensome for practitioner or provider staff or for members. No information is required that is not in fact used in the evaluation or recording of the request; in particular, submission of member records are not be routinely required.					
g. The CMO does not prohibit providers from advocating on behalf of members within the utilization management process. Guidelines: CMO subcontracts do not implicitly or explicitly prohibit a provider from assisting members in obtaining authorization for a service or pursuing appeal requests, for example by helping to document medical necessity or supplying scientific evidence of the appropriateness on the requested service.	**5**	**4**	**3**	**2**	**0**
h. The CMO shall provide that compensation to individuals or entities that conduct utilization management or prior authorization activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services necessary to achieve outcomes to any member. Guidelines: CMO contracts with individual reviewers or with utilization review organizations may provide for compensation on the basis of time and/or of total numbers of authorization requests processed, but do not include any bonus or other incentive for denial of authorization.	**5**	**4**	**3**	**2**	**0**